STATE OF MAINE
DEPARTMENT OF HEALTH AND HUMAN SERVICES

AUTHORIZATION TO RELEASE INFORMATION

NAME_____ **DOB** _____ **SSN** _____

PRINT LEGIBLY OR TYPE

I hereby authorize _____

To DISCLOSE to: **OR** **To OBTAIN from:** ☐

(Mark appropriate box)

Name of Person or Organization: _____

Address _____

_____

Fax #: _____ Phone # to verify: _____

(Include fax number and phone number to verify receipt ONLY if fax is being used)

INFORMATION TO BE DISCLOSED

CHECK **YES** or **NO** for each of the following and specify the information being requested in the blank:

____**YES** ___**NO** Alcohol and/or Drug Treatment_____

(NOTE: Authorization is required to share ANY information about alcohol/drug treatment, whether spoken or written)

____**YES** ___**NO** Assessments _____

____**YES** ___**NO** Crisis Plans/Emergency Services_____

___**YES** ___**NO** Discharge Summaries_____

____**YES** ___**NO** Laboratory/Diagnostic Reports_____

____**YES** ___**NO** Medical History and/or Physicals_____

____**YES** ___**NO** Outpatient Treatment_____

____**YES** ___**NO** Psychiatric History and Evaluations_____

____**YES** ___**NO** Psychological and/or Psychosocial History, Reports, Evaluations_____

____**YES** ___**NO** Service/Treatment Plan(s)_____

PURPOSE FOR DISCLOSURE

CHECK **YES** or **NO** for each of the following:

_____**YES** ____**NO** Ongoing treatment/care management services
_____**YES** _____**NO** Coordination with current treatment provider
_____**YES** ____**NO** Coordination with family/concerned persons
_____**YES** ____**NO** Development of Service/Treatment/Crisis Plans
_____**YES** ____**NO** Assistance to obtain government benefits
_____**YES** _____**NO** Eligibility determination entitlements, insurance or employment
_____**YES** ___**NO** At request of Individual
_____ **YES** ___ **NO** Other (specify) _____

Please *INITIAL YOUR RESPONSE to* EACH of the following statements:

STATE OF MAINE
DEPARTMENT OF HEALTH AND HUMAN SERVICES

____I DO ____I DO NOT authorize disclosure of information that refers to treatment or diagnosis of alcohol or drug abuse. I understand that it cannot be re-disclosed without my specific consent.

____I DO ____ I DO NOT authorize disclosure of information that refers to treatment or diagnosis of HIV or AIDS. I understand that some individuals about whom such disclosures have been made have encountered discrimination from others in the areas of employment, housing, insurance, or social/family relations.

_____I DO ____I DO NOT wish to review, prior to its release, any information I have authorized for release.

I understand that the information indicated is protected by law and cannot be released without my written permission, unless otherwise specifically permitted by law. I understand that I have the right to review information and material released. I understand I have the right to revoke this authorization in writing at any time. I understand that I do not need to sign this form to receive services and that I may receive a copy of this authorization if I wish. I understand that I may review the DHHS *Notice of Privacy Practices* before I sign this form. The benefits, risks, and consequences of releasing or not releasing this information have been explained to me

_____ _____
Client Signature or Mark Date

_____ _____
Witness Signature Date

_____ _____
Guardian/Parent/Legal Representative Signature (specify role) Date

This authorization is effective until _____ (Date not to exceed one [1] year)**.**

Revocation of this Authorization:

_____ _____ _____
Signature/Mark Of Person Revoking Authorization Relationship Date

_____ _____ _____
Witness Signature (if Mark/Stamp above) Witness Printed Name Date

Additional Information for Persons/Organizations Receiving either Substance Abuse or Mental Health Information

For Persons/Organizations Receiving Substance Abuse Information:
This information has been disclosed to you from records protected by Federal confidentiality rules (*42 CFR Part 2*). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by *42 CFR Part 2.* A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

For Persons/Organizations Receiving Mental Health Information:
This information has been disclosed to you from records protected by State confidentiality laws (*34-B M.R.S.A. §1207; Rights of Recipients of Mental Health Services*). This information remains confidential and should not be disclosed any further except as expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by law.